Payment Error Rate Measurement Program
c/o The Lewin Group
CMS Statistical Contractor
3130 Fairview Park Dr.
Falls Church, VA 22042

To: All States Selected for the FY 2006 Medicaid Payment Error Rate Measurement Program

From: The Lewin Group, Statistical Contractor

Cc: Centers for Medicare and Medicaid Services

Date: September 20, 2006
Note: this replaces the version sent on March 20, 2006

Re: Claims Data Submission Instructions for FY2006

1. Overview

The purpose of the Medicaid Payment Error Rate Measurement (PERM) project is to estimate state-level payment error rates and, from these, national-level payment error rates for Medicaid. The basic claims sampling method is to draw a random sample of line items for Medicaid fee-for-service (FFS) claims, review them to determine errors and the dollar amounts and calculate an error rate.

On November 18, 2005, the Centers for Medicare & Medicaid Services issued a letter to state Medicaid directors regarding CMS' national contracting strategy to measure improper payments in the Medicaid program as required by the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The national contracting strategy involves three contractors: a statistical contractor (SC), a documentation/database contractor (DDC), and a review contractor (RC). CMS has selected The Lewin Group as the statistical contractor. Lewin has worked with CMS and 38 state Medicaid and SCHIP programs since 2001 to pilot test various methodologies to measure payment error in Medicaid and SCHIP.

As the statistical contractor, Lewin's primary responsibilities are to:

- Determine the sample size of claims that will be reviewed for each state,
- Determine the number of claims or line items to be sampled in each strata for each time period,
- Select a random sample of line items for review from each state on a quarterly basis,
- Transmit the sampled claims and line items to the documentation/database contractor and review contractor, and
- Calculate each state's error rate and the national error rate for FY 2006 after the reviews are completed.

The cycle is expected to take approximately two years, with the sampling activities concentrated in the first four quarters and the error rate calculation occurring at the end of the review cycle.

To select a random sample of line items for review, Lewin will need to obtain claims data from each state selected for participation in the PERM program in FY2006. As described in the November 18 letter from CMS, states should provide these data on a quarterly basis, within 15 days of the end of the quarter. This document outlines the process and formats for states to submit these data to The Lewin Group, including:

- Overview of sampling approach
- Claims/payments to be included in the sample
- Stratification approach
- Claims data submission options and timeframes
- Other data and documentation requested from the states to support the claims selection

As Lewin has extensive experience working with state Medicaid claims data, we are aware of the complexity of the technical issues regarding the size and scope of this data request. The instructions in this document provide an overview of the various components.[1] However, Lewin's technical staff will be available to states throughout the process to answer questions, provide guidance, and resolve technical issues. Lewin staff are accessible through a central email inbox, which all project staff have access to and check daily: **cms.perm@lewin.com**. Please send questions to this address and we will route them to the appropriate person, who will follow up by phone or email. We will maintain a list of questions and answers on our PERM website: **www.cms-perm.org**. We will also be available to consult by phone as needed.

Finally, we know that no two state Medicaid systems are alike, and that there are substantial variations in state resources, experience with the PERM model, and IT flexibility. Wherever possible, we have outlined alternative options for data submission with varying levels of effort from both the states and Lewin. We will work with each selected state to develop the data submission and sampling approach that works best for that state, taking into account the state's unique circumstances, resources, and systems capability.

2. Claims data needs

The Lewin Group is responsible for collecting claims data from states for use in the PERM project, but the data are ultimately used by all three contractors. Below is a brief overview of how each contractor uses the data.

- Statistical Contractor (SC): The SC will draw a stratified random sample from the quarterly universe files submitted by the states. The sampling unit is the lowest separately

[1] The DDC and RC will provide separate guidance regarding data and documentation needed to support the payment error rate measurement program.

priced unit on a beneficiary-specific claim. This is typically a line item. However, for some types of claims, such as those representing diagnostic related groups (DRGs), the lowest separately priced item is the claim itself. Gross adjustments or lump sum payments or recoveries from providers are not included in the universe file or the random sample. To accomplish the sample selection, the SC uses only the claim ID and line item number, strata assignment, original date of payment, and paid amount. Preferably, the paid amount is the paid amount reflective of any adjustments made within 60 days of the original date of payment. However, some states have difficulty providing this level of precision in the universe file, and the SC can also work with the original paid amount. States have the option of providing either the full claims records or an extract of the claims record. For those states that provide the full claim records, the SC applies the record layout to extract the five fields needed for the sample selection. As an alternative, states can provide a simple data extract of the five fields listed above, plus the applicable MSIS code or a code indicating provider type for the initial sampling, then provide the full data for the sampled line items and claims. The additional fields, MSIS code and provider type, are included to facilitate the SC's quality control procedures for validating the data.

- Data Documentation Contractor (DDC): The DDC must request the medical records associated with the sampled services in strata 1 through 6 (defined below), which requires sufficient information to contact the servicing provider and identify the patient and date of service to request the medical record, and then track the information received by the claim/line item identifier for distribution to the Review Contractor. The DDC also must be able to identify those sampled claims or line items in strata 1 through 6 which are Medicare crossovers; these claims will not be subject to medical review. In practice, the more detail that is available regarding the billing provider, servicing provider, diagnosis, procedures, and beneficiary, the easier it is for the provider to identify the proper records and return them to the DDC within the 90-day window. Records that cannot be obtained within 90 days are counted as payment errors for PERM purposes.

- Review Contractor (RC): The RC is responsible for medical review and claims processing review, and consequently needs all of the information associated with the sampled claims as well as the supporting documentation provided by the DDC. For the medical review, the RC will refer to the claims data in combination with the medical record and the coverage and benefit policies provided by each state. For the processing review, the RC will need not only the history and detail for each of the sampled claims, but additional information from the beneficiary and provider files as well as the copies of the states' payment policies and fee schedules. The beneficiary files will include TPL information, spend down indicators, eligibility history, aid category (which will help determine copayment expectations and benefit coverage), and enrollment in other Medicaid programs (e.g., Home and Community-Based Waiver) that impact claim payment policies, benefit limitations, etc. Provider file data will establish rules regarding application of fee schedules, authorization for provision of certain services, etc.

3. Overview of sampling approach

Lewin will select a sample of Medicaid claims or line items from a universe of data provided each quarter by the 17 selected states. See Appendix A for definitions of the terms below as they apply to the Payment Error Rate Measurement program.

Universe

The Medicaid FFS universe consists of all adjudicated FFS Medicaid claims or line items which were originally paid (paid claims) or for which payment was requested but denied (denied claims) from October 1, 2005 through and including September 30, 2006, and for which there is federal financial participation. Only claims or line items that are paid for in whole or in part by Title XIX financial participation (FFP) dollars are included in the Medicaid FFS universe (state-only and Title XXI services that are processed through a Medicaid system are excluded). For purposes of the PERM program, the FFS universe includes, in addition to regular claims payments, fixed payments made on behalf of beneficiaries, including Medicare Part A and Part B premiums made on behalf of Medicaid beneficiaries and primary care case management (PCCM) payments. Medicaid and Health Insurance Premium Programs (HIPP), which pay for private health insurance premiums when it is more cost-effective than providing full Medicaid/SCHIP coverage, are also included, if applicable. The universe also includes zero-paid claims and line items (i.e., a valid claim that the state had no additional liability to pay on due to, for example, third party liability or a Medicare payment exceeding the state allowable charge).

Summary:

- Include only payments with an original paid or adjudicated date within the relevant quarter being sampled
- Include claims or line items which were paid (paid claims), including zero paid claims, or for which payment was requested, adjudicated, but denied (denied claims)
- Include all fee-for-service claims or line items that are paid for in whole or in part by Title XIX financial participation (FFP) dollars, even if the payments are not made through the claims system (e.g., Medicare Part A and Part B premiums) or are made by other agencies within the state

Sample frequency

States will transfer data containing all adjudicated Medicaid fee-for-service claims, including adjudicated denials, on a quarterly basis for the each of the four quarters of FFY 2006. Inclusion in the quarterly sample will be based upon the original payment date or, for denied claims, adjudication date.

Paid amount should be defined as the net claim or line item as paid or adjusted within 60 days of the original payment date.[2]

Data must be sent to Lewin by the 15th of the following month, according to the following schedule:

Quarter	Last Day of Quarter	Date Lewin Will Request Data	Date State Must Send Data
Quarter 1	December 31, 2005	December 20, 2005	January 15, 2006
Quarter 2	March 31, 2006	March 20, 2006	April 15, 2006
Quarter 3	June 30, 2006	June 20, 2006	July 15, 2006
Quarter 4	September 30, 2006	September 20, 2006	October 15, 2006

If the due date falls on a weekend or holiday, the data must be sent by the next business day.

Sampling units are selected for inclusion in each quarter's data only if the original date of payment falls within the quarter. Adjustments made within the quarter to claims originally paid prior to the quarter must be excluded from the universe. The chart on the next page illustrates the selection criteria for paid date and amount paid.

Summary:

- Include only payments (paid and denied claims) with an original paid date within the sampled quarter
- Include the net claim or line item as paid or adjusted within 60 days of the original payment date (adjustments for claims or lines paid towards the end of the quarter will be requested after the sample is drawn)
- Do not include adjustments made after 60 days from the original paid date, even if state policy allows adjustments to be made over a longer timeframe
- Do not include adjustments to payments with an original paid date prior to the beginning of the quarter

[2] If the state is unable to compile a universe file with paid amount calculated as the amount paid as of the 60th day of the original payment date, paid amount can be defined as the amount paid on the original payment date. The state must inform the SC of the use of this option with the data submission. Information on adjustments to claims submitted with only original paid dates will be requested after the sample is selected.

Example: Selection of Sampling Units for FFY2006, Quarter 2 (Jan - Mar)
Application of Payment Date and Payment Amount Criteria

	Claim #1	Claim #2	Claim #3	Claim #4	Claim #5
December					Original payment 12/15; $45
January	Original payment 1/12; $45		Original payment 1/6; $280		
February	Adjusted 2/27; new final paid amount $60	Original payment 2/28; $1,200			Adjusted 2/2; new final paid amount $60
March	Adjusted 3/25; new final paid amount $70			Original payment 3/31; $500	
April		Adjusted 4/20; new final paid amount $960			
May			Adjusted 5/12; new final payment $375	Adjusted 5/20; new final payment $450	

Included in Q2 universe file provided 4/15:	**Paid date = 1/12; amount paid = $60**	**Paid date = 2/28; amount paid = $1,200**	**Paid date = 1/6; amount paid = $280**	**Paid date = 3/31; amount paid = $500**	**Not included in Q2, original paid date prior to quarter**
If claim selected for sample, state provides updates:	No update because 3/25 adjustment occurred more than 60 days after 1/12	Adjustment made on 4/20 provided to SC (since this is within 60 days of original payment date of 2/28)	No update; adjustment occurred more than 60 days after original payment date	Adjustment made on 5/20 provided to SC (since this is within 60 days of original payment date of 3/31)	N/A

Sampling unit

The sampling unit is a line item, fixed payment, or individually priced service tied to a single beneficiary. States must provide universe data at the sampling unit level. Throughout this document, we often use the term "claim" to refer to the sampling unit, but the relevant payment may in fact be a line item, fixed payment, or other individually priced service. For example, in cases of payments made for inpatient hospital services, the sampling unit is the individually priced service for which the provider is reimbursed. Because many states use a prospective payment or diagnosis-related groups (DRG) system for inpatient stays, the smallest independently priced item may be the DRG itself. In this case, the DRG (or claim header) is the sampling unit. Similarly, if the inpatient stay is priced as an all-inclusive per diem payment amount, the sampling unit would be at the claim level. In these cases, we would count the whole payment as one sampling unit, regardless of the number of individual line items included on the claim. For a lab claim with several separately priced tests, each line item on the claim would be defined as a sampling unit and sampled separately. A claim for lab tests paid on a bundled basis would be treated as a single sampling unit. In no case can a sampling unit be represented multiple times in the universe file, or included in more than one universe file across quarters.

Summary:

- Sampling unit is the smallest independently priced item and may include claims, line items, fixed payments (e.g., Medicare premiums, primary care case management payments) or grouped or bundled payments (e.g., DRGs)

- States must provide data at the smallest independently priced item level (i.e., each record in the data file must represent a single sampling unit), with individual identifiers (line item number or claim number and line identifier)

- Sampling units must be tied to a single beneficiary; gross adjustments are not included

- The sampling unit must reflect the amount paid for that sampling unit—the amount paid for the specific line item for line item level units, or the amount paid at the claim header level for claim-level sampling units

Strata

A proportional, stratified random sample will be drawn for Medicaid FFS. Paid service strata definitions are based on the Medicaid Statistical Information System (MSIS), with some PERM-specific additions for payment and service types not included in the MSIS specifications. The MSIS Type of Service definitions have been provided in Appendix B for convenience, but states may prefer to refer to the complete MSIS specifications found on the CMS website.[3]

[3] More information on MSIS can be found on the CMS website: new.cms.hhs.gov/MSIS. A description of how Medicaid payments should be reported for MSIS, including the MSIS service category codes, can be found in the MSIS Tape Specification and Data Dictionary. This can be viewed in PDF form:

Sampling units which are not defined as managed care but which reflect payments made on a capitated basis, regardless of whether a service was received by the beneficiary within the service period, must be categorized as Stratum 7. For example, a state may contract with a taxicab company to provide non-emergency transportation services for children with special health care needs in the company's service area. The service, if reimbursed on a per beneficiary, per month basis, would be reflected in the universe data as follows:

- Each sampling unit would be at the beneficiary and service month level
- The sampling unit would be at the claim header level; typically there would be no line item detail in the full claim data
- The amount paid would be the monthly capitation amount per beneficiary
- The service dates in the full claim record would reflect the month for which capitation was made

In the case of capitated services, the strata assignment is always Stratum 7 rather than the stratum describing the nature of the service (e.g., stratum 6 for transportation).

The Medicaid sampling strata include:

Stratum 1: Hospital Services
Inpatient hospital services (MSIS = 01)

Stratum 2: Long-Term Care Services
Nursing facility services (MSIS = 07)
Inpatient psychiatric facility services for individuals 21 and under (MSIS = 04)
Other mental health facility services for individuals 65 or older (MSIS = 02)
ICF/MR services (MSIS = 05)
Religious non-medical health care institutions (MSIS = 39)

Stratum 3: Other Individual Practitioners, Clinics
Outpatient hospital services (MSIS = 11)
Clinic services (MSIS = 12)
Physician services (MSIS = 08)
Other licensed practitioner services (MSIS = 10)
Physical/occupational/speech therapy, etc. (MSIS = 34)
Rehabilitative services (MSIS = 33)
Dental services (MSIS = 09)
Nurse midwife (MSIS = 36)
Nurse practitioner (MSIS = 37)

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new.cms.hhs.gov/MSIS/Downloads/msisdd05.pdf. Attachment 4 to the MSIS Tape Specification and Data Dictionary contains the Type of Services References that were adapted for use by PERM.

Stratum 4: Prescription Drugs
Separately billed prescribed drugs (MSIS = 16)

Stratum 5: Home and Community-Based Services
Home health services (MSIS = 13)
Private duty nursing (MSIS = 38)
Personal care services (MSIS = 30)
Hospice services (MSIS = 35)
Targeted case management services (MSIS = 31)

Stratum 6: Other Services and Supplies
Lab and X-ray services (MSIS = 15)
Transportation (MSIS = 26)
Other care (e.g., prosthetics, eyeglasses, and HCBS waiver services that cannot be placed in one of the Stratum 5 categories of service) (MSIS = 19)
Sterilization services (MSIS = 24)
Abortions (MSIS = 25)
Unknown (There is no official MSIS category, please use "90")

Stratum 7: Fixed Payments on Behalf of Individual Beneficiaries (if applicable)
Primary care case management payments (MSIS = 22)
Medicare Part A premiums (There is no official MSIS category, please use "91" for Part A)
Medicare Part B premiums (There is no official MSIS category, please use "92" for Part B)
Health Insurance Premium Payments (HIPP) (There is no official MSIS category, please use "93")
Other non-managed care payments made on a capitated basis

Stratum 8: Denied Payments (There is no official MSIS category, please use "99")

Services not explicitly defined in the MSIS data dictionary (with the exception of Medicare payments, HIPP, and denials) and which are not paid on a capitated basis are considered "Other Care" and should be included in the Stratum 6 "Other Services and Supplies."

Denied claims/line items are not defined by MSIS. For the PERM program, denials include any claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and not approved for payment in whole or in part. Denials do not include claims submitted by providers but rejected from the claims processing system prior to adjudication. Please contact Lewin if you have specific questions about how denials should be defined within the constraints of your processing system.

Medicare crossover claims and zero paid claims should be included in the stratum where the service in which Medicaid is paying would fall. If the service type cannot be distinguished, crossover claims should be included in the "other services and supplies" stratum.

Note that because several elements of the PERM universe are not included in states' regular MSIS submissions (e.g., denials, Medicare premiums), states must submit a separate universe for the PERM program.

Summary:

- All claims and line items are assigned to one of the eight strata above
- Lines on a single claim can be assigned to different strata, although each line item can be represented only once across strata (e.g., some may be paid and go into the appropriate service strata, while others are denied and go into strata 8)

Sample size

Lewin will draw a random sample of claims/line items, stratified by the eight strata (seven service strata plus denials), for each state. The sample drawn will be of sufficient size to estimate the payment error rate at a precision level of +/- 3 percentage points with 95% confidence. In the PAM/PERM pilots, we achieved this precision level and confidence with sample sizes of 800 to 1200 claims per state (i.e., 200 to 300 claims per quarter). The sample from each paid stratum (i.e., strata 1 through 7) will be proportional to the expenditure share for that stratum of total Medicaid fee-for-service expenditures (denied claims are addressed differently because their expenditure share is zero). For example, if the inpatient stratum 1 constitutes 20% of Medicaid paid fee-for-service expenditures, then 20% of the sampling units from the paid fee-for-service claims universe will be randomly sampled from the inpatient stratum.

Summary:

- Lewin will draw a random sample each quarter, distributed among the 8 strata

Sample selection and transmission

After applying initial quality control checks on the data, Lewin uses the unique universe from each quarter to develop a summary of claims (total dollars and number of payments) by strata and month. This summary is reviewed and compared to data from the previous fiscal year and to previous quarters to ensure that it is consistent. In some cases, the initial summary reveals potential problems with the universe and the state is asked to provide additional data or (potentially) replacement data. These data must be provided within two weeks of request. If there are clarifying issues or questions about the data that do not require the submission of additional data, we ask that these be responded to within five days.

Once the universe summary is reviewed and approved, Lewin will draw the sample of claims for each quarter. In general, this will occur within 30 calendar days of receiving the universe files from the state (recognizing that, due to the variety of claim formats and data systems used by the states, it may take slightly longer to establish the necessary sorting systems in the first quarter).

Lewin will send the state back the list of sampled claims and/or line items, in the same format that it was provided to Lewin. The state will need to provide details for the sampled items (e.g.,

claims details, beneficiary and provider information, adjustments made within 60 days of original paid date) within 14 days.

Lewin will review the second submission for completeness and forward the data to the RC and DDC, who will begin requests for documentation and other review processing activities. If the state has not submitted sufficient information for the DDC and RC to complete their respective activities (e.g., provider and beneficiary details so the DDC can develop medical record request letters, payment details so the RC can conduct a processing review), Lewin will request additional information from the state.

4. Treatment of unusual situations

Adjustments

The PERM guidelines require that adjustments made within 60 days of the original paid date must be included in the review process, which will consider the net amount paid (original paid amount with additions/subtractions due to adjustments that occurred within 60 days) in calculating the error rate.

States have two options for submitting adjustments:

1. Submit claims/line items with the amount paid reflecting the payment on the original payment date. After Lewin has randomly selected the sample and sent the list of selected items back to the state, the state will compile adjustments that occurred within 60 days of the original paid date for each sampled item, and return this information to Lewin along with the remaining claim detail.

2. Submit claims/line items with the amount paid reflecting the net amount inclusive of any adjustments made up to 60 days following the original payment date. For claims paid in the second and third months of the quarter, the state will not have 60 days of claims adjustment history by the time the universe must be sent to Lewin for sampling. Therefore, after the SC randomly selects the sample and sends the list of selected items back to the state, the state must compile information on adjustments that occurred within 60 days of the original paid date for all sampled items for which this information was not included in the original universe, and return this information to Lewin along with the remaining claim detail.

We understand that different Medicaid Management Information Systems maintain different levels of historic detail on adjustments and will work with states to identify mechanisms to appropriately account for adjustments if neither of these proposed approaches will work for certain systems.

Medicare Part A and Part B premiums

Although most non-claims-based sampling units are excluded from the universe, Medicare Part A and Part B premiums should be included in the universe. Since many states pay these premiums on an invoice basis rather than a claims basis, it may be necessary to create dummy claims in order to sample individual premium payments. Each dummy claim should show the beneficiary ID, payment amount, service type (i.e., Medicare Part A or Medicare Part B premium) and date of payment. Alternatively, states can submit a separate data file that lists all of the

beneficiaries for whom Part A and Part B premiums were made and the amount and date of each payment so that the SC can randomly sample from the list. Payments for HIPP premiums and PCCM capitation payments should be treated similarly and included in Stratum 7.

5. Initial claims data submission options

As noted above, sampled states must send a data file each quarter containing all adjudicated sampling units (claims, line items, and fixed payments) for the quarter, including those that were denied payment. States should validate the universe each quarter, prior to submission. This includes determining that the following universe inclusion criteria are met:

- Only sampling units with an original paid date (or adjudicated date, for denials) within the quarter are included
- Sampling units from all 8 strata are included
- Each sampling unit is assigned to the appropriate stratum
- Records reflect the smallest independently priced service level, which may be a claim, line item, or fixed payment
- Payments that are solely adjustments (to payments made during or prior to the quarter) are excluded from the universe
- Records are limited to Title XIX claims and to fee-for-service claims as defined in this document

We will not provide states with a specific record layout. Instead, we will work with each state to obtain and analyze data in a format that can be produced by the state's system and read by Lewin's system. In most cases, we believe that this will consist of a flat file of all adjudicated claims and denials, sorted into strata as defined above. The state will need to provide Lewin with record layouts and a data dictionary to permit the data to be read and sampled. See section 6 for more information on submission formats.

We have identified two alternate mechanisms for data transmission and sampling. We will work with each state to identify the most efficient mechanism for each state, taking into account the state's unique circumstances, resources, and systems capability. In addition, each state must send the necessary documentation to correctly analyze the claims files, including file names, record layouts, data dictionaries, and other data processing systems manuals. States were asked to provide these 30 days prior the first quarter data submission.

The two approaches are:

> **1. Complete claims file.** In the single-step process, the state submits a complete flat file of all adjudicated sampling units (payments and denials) for the quarter, identified by strata. This file will contain complete claims information for each sampling unit in order for the statistical contractor to select the sample, the documentation database contractor to obtain records, and the review contractor to review the claim. At a minimum, the fields

listed in Appendix C would be included in the complete claims file (**as applicable** to the claim type and state payment system). If there are doubts regarding fields to include, please contact the SC .

Lewin will select a random sample by month and strata, and email a password-protected file back to the state listing all of the selected sampling units (this file will not contain personal health information). The state should then send information on any additional adjustments or details to Lewin (per the data submission requirements outlined below), which we will forward them to the DDC and RC.

2. Claims extract. In the two-step process, the state submits a flat file containing an extract of the claims information for all adjudicated sampling units (payments and denials) for the quarter, sorted by strata. This file will contain enough fields for Lewin to sample the item and identify it back to the state. The required fields will be limited to[4]:

- Unique claim ICN
- Line item number (zero if sampling unit is at the claim header level)
- Date of original payment
- Paid amount (amount paid as of 60 days after original payment date or, if the state chooses, the amount paid on the original payment date; $0 for denied claims)
- Provider type, MSIS category, or similar variable
- Strata assignment (1 through 8)

From the claims extract, Lewin will select a random sample by month and strata and send the list of selected claims/line items back to the state. If the state is unable to stratify the data, Lewin will accept an unsorted file, sort the data into strata, and select a random sample by strata. Lewin will email a password-protected file back to the state listing all of the selected sampling units, with all associated fields provided in the original extract. For these sampling units, the state should submit the claim history and complete claim information for the claim, payment, or claim that includes the sampled line item (see Appendix C for details). Claim history, in this context, means the original claim plus any adjustments made within 60 days of the original paid date. Lewin will then transmit the detailed claims information to the DDC and RC.

6. Follow-up claims data submission

For all states, additional information on sampled line items and claims should be returned to Lewin within two weeks of receipt of the sample by the state. In addition, we may ask states to provide additional data regardless of which approach (full claims or extract) is used. For example, the claims records may not include sufficient information regarding the provider for the DDC to develop a medical records request or for the review contractor to conduct the processing review. In this case, the state may need to provide an additional provider file or other claims

[4] The state may include additional fields if they may be helpful in stratifying or sampling the data. Data definitions, field codes, and crosswalks should be included for all fields provided in the extract.

detail. In addition, states may need to provide updated information on adjustments after the sample is selected, as described earlier.

If the state anticipates that it will not be able to return the claim details within two weeks, it should notify Lewin as soon as possible so that we may notify the other contractors. If the claims details are not returned within two weeks, CMS will ask the state to submit an action plan for completing the quarterly sample.

7. Data submission formats

Due to the complexity of computer platforms and software products used by different states, it is not possible for us to process data from every platform or in certain software product formats. Therefore, we request that states provide either complete or extract data in a universal text format data (also called "flat format" or "ASCII format") accompanied by a detailed record layout, an MS Windows SAS format, or parsed and fully labeled in an Excel spreadsheet. Lewin will process flat file data on an IBM mainframe or SAS server, depending on the size of the data and our software tools. If states use systems compatible with Lewin's systems (e.g., PC-based SAS server and IBM mainframe), they may send claims data in a PC-based SAS dataset or data files that can be read on an IBM mainframe; in fact, files in the MS Windows version of SAS are preferred, particularly for the extract data. Data dictionaries for those fields using codes specific to the state or the state's fiscal agent will need to be provided with the claim data.

While we do not prescribe a specific record or file layout, the following suggestions make it easier for Lewin to read and analyze each state's data:

- If data are in the same format, it is easiest if it is all included in the same file (e.g., include all three months of Strata 1 data in the same file).

- Except for the first row of the field names, please do not include any log or summary information at the beginning or the bottom of the data file.

Data transfer from the states can be accomplished using several methods. Lewin's systems and our mainframe vendor are capable of reading electronic data stored on a variety of media, including cartridges, tapes, CDs, and DVDs. We prefer that data transfer be accomplished by mailing (via courier such as FedEx or registered mail) a password-protected file. The passwords can be emailed to the cms.perm@lewin.com email address. If CDs or DVDs are used, states should send two identical copies and label each with the state, fiscal year, and quarter. If a single quarter's data spans multiple DVDs, please include the file names on the labels. States that submit extracts can then send the complete claims records for the selected claims on CD or DVD. The transmission of data with personal health information (PHI) should comply with all federal and state laws and regulations. Any data that includes protected health information should not be sent via email.

Due to the large number of quarterly universe files, replacement and correction files, and sample detail files Lewin receives from the states, we ask that the Data Transmission Cover Sheet included in Appendix D be completed and emailed to us (cms.perm@lewin.com) with every data submission, preferably the day the data is sent.

If a state cannot produce cartridges or tapes and the quarterly file is too large to fit on CDs or DVDs, we offer the option of using portable, external hard drives for the transfer. These drives have a capacity of 100-400 gigabytes, which will be sufficient to transfer the quarterly claims in flat file format for most states (if necessary, we can provide larger capacity drives to states with larger amounts of data or with data provided in a format requiring more capacity). These drives will be sent to states via FEDEX and can be returned via FEDEX or other shipper that provides tracking capability. States will be asked to password protect the data stored on the drives and send the passwords to Lewin under separate cover.

Note that Lewin's data systems comply with data confidentiality and security rules in the US and overseas and Lewin has established security systems consistent with National Institute of Standards and Technology (NIST) assessment methodologies and guidelines. Lewin has extensive controls to ensure that information handling resources are protected against unauthorized loss, modification, disclosure, or damage. This includes both systems and physical controls. The mainframe system that we use under contract also employs these principles and the mainframe vendor has agreed to provide a very high standard of security to protect both the data and its confidentiality. Lewin has executed a Business Associate Agreement with CMS, so it is not necessary for states to sign individual Business Associate Agreements with Lewin prior to the transfer of data.

APPENDIX A

DEFINITIONS

Adjudicated: In reference to denied claims, adjudicated refers to the date the decision to deny the claim is made. In reference to paid claims, adjudicated refers to the date the money is obligated or approved to pay the claim. Note, this is not the day the check is issued to the provider, but is the date the decision is made to obligate funds (usually soon after the decision is made to approve the claim).

Adjustment: Change to a previously submitted claim that is linked to the original claim.

Claim: A request for payment, on either an approved form or electronic media, for services rendered relating to the care and treatment of a disease or injury. A claim may consist of one or several line items or services.

Denied claim or line item**:** A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment and not approved for payment in whole or in part.

Fee-For-Service (FFS): A traditional method of paying for medical services under which providers are paid for each service rendered.

FFS processing error: A payment error that can be determined from the information available from the claim or from other information available in the state Medicaid/SCHIP system (exclusive of medical reviews and eligibility reviews).

Health Insurance Premium Payment (HIPP): States can choose to have Medicaid pay beneficiaries' private health insurance premiums when it is more cost-effective than paying for Medicaid services. These payments are included in Stratum 7 for the PERM pilot.

Line item: An individually-priced service presented on a claim for payment. Items individually listed but priced in a bundled service rather than being priced individually are not considered "line items."

Managed care: A system where the state contracts with health plans on a prospective full-risk or partial-risk basis to deliver health services through a specified network of doctors and hospitals. Providers may receive a capitated payment for providing all medically necessary care to enrollees or may be paid on a fee-for-service basis.

Medicaid: A joint federal and state program that provides medical care to categories of people (e.g., pregnant women, medically needy) with low incomes and limited resources.

Medicaid Statistical Information System (MSIS): The MSIS, housed by CMS, collects statistical data from each of the states on an annual basis (using form HCFA-2082). The system includes aggregated statistical data on eligibles, recipients, services, and expenditures during a Federal fiscal year (i.e., October 1 through September 30).

Medical review error: An error that is determined from a review of the medical documentation compared with the information presented on the claim.

Medicare: The federal health insurance program for: people 65 years of age or older and certain younger people with disabilities or End Stage Renal Disease. Beneficiaries must pay (or have paid on their behalf) premiums for the two main portions of Medicare: Part A (hospital) and Part B (physician) services.

Non-claims based sampling unit: Sampling units that are not related to a particular service provided, such as Medicare Part A or Part B premiums.

Overpayment: Overpayments occur when the state pays more than the amount the provider was entitled to receive or paid more than its share of cost.

***Paid claim*:** A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and for which a payment was issued.

Partial error: Partial errors are those that affect only a portion of the payment on a claim.

Primary Care Case Management (PCCM): PCCM programs operate in a manner between traditional fee-for-service and risk-based HMO managed care. Under PCCM, consumers are linked to a primary care provider who coordinates their health care. Providers are paid on a fee-for-service basis, and receive small additional payments to compensate for care management responsibilities. Providers are not at financial risk for the services they provide or authorize. For PERM purposes, case management fees are included in Stratum 7.

Sampling unit: The sampling unit for each sample is an individually priced service (e.g., a physician office visit, a hospital stay, a month of enrollment in Medicare). The sampling unit can include claim, line item, or premium payment.

Surveillance and Utilization Review Subsystem (SURS): The State's SURS is used to identify beneficiary over or under utilization and aberrant provider practices for education and potential sanction purposes.

Third Party Liability (TPL): The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. In cases of available TPL, Medicaid is payer of last resort.

Underpayment: Underpayments occur when the state pays less than the amount the provider was entitled to receive or less than its share of cost.

Universe: The universe is the set of sampling units from which the sample is drawn and the set of payments for which the error rate is inferred from the sample. The term "claim" is used interchangeably with the term "sampling unit."

***Zero-paid claim*:** A claim or line item that has been accepted by the claims processing or payment system, adjudicated for payment, and approved for payment, but for which the actual amount remitted was zero dollars (i.e., applied deductibles or offset amounts).

APPENDIX B

Medicaid Statistical Information System (MSIS) Service Definitions

Note: This is taken from Attachment 4 (pages 157 to 166) of the MSIS Tape Specifications and Data Dictionary, available online at new.cms.hhs.gov/MSIS/Downloads/msisdd05.pdf. Please refer to the complete MSIS Tape Specifications and Data Dictionary for more information.

The following definitions are adaptations of those given in the Code of Federal Regulations. These definitions, although abbreviated, are intended to facilitate the classification of medical care and services for reporting purposes. They do not modify any requirements of the Act or supersede in any way the definitions included in the Code of Federal Regulations (CFR).

Effective FY 1999, services provided under Family Planning, EPSDT, Rural Health Clinics, FQHC's, and Home-and-Community-Based Waiver programs will be coded according to the types of services listed below. Specific programs with which these services are associated will be identified using the program type coding as defined in Appendix C.1.

NOTE: For hard-copy 2082 submissions only, continue to report program types listed in Appendix C.1 as types of services.

1. Unduplicated Total.--Report the unduplicated total of recipients by maintenance assistance status (MAS) and by basis of eligibility (BOE). A recipient receiving more than one type of service is reported only once in the unduplicated total.

2. Inpatient Hospital Services (MSIS Code=01) (See 42 CFR 440.10).--These are services that are:

- Ordinarily furnished in a hospital for the care and treatment of inpatients;
- Furnished under the direction of a physician or dentist (except in the case of nurse-midwife services per 42 CFR 440.165); and
- Furnished in an institution that:

  -Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

  -Is licensed or formally approved as a hospital by an officially designated authority for State standard setting;

  -Meets the requirements for participation in Medicare (except in the case of medical supervision of nurse-midwife services per 42 CFR 440.165); and

  -Has in effect a utilization review plan applicable to all Medicaid patients that meets the requirements in 42 CFR 482.30 unless a waiver has been granted by the Secretary of Health and Human Services.

Inpatient hospital services do not include nursing facility services furnished by a hospital with swing-bed approval. However, they include services provided in a psychiatric wing of a general hospital if the psychiatric wing is not administratively separated from the general hospital.

3. Mental Health Facility Services (See 42 CFR 440.140, 440.160, and 435.1009).--An institution for mental diseases is a hospital, nursing facility, or other institution that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including medical care, nursing care, and related services. Report totals for services defined under 3a and 3b.

3a. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under (MSIS Code=04) (See 42 CFR 440.160 and 441.150(ff)). --These are services that:

- Are provided under the direction of a physician;
- Are provided in a psychiatric facility or inpatient program accredited by the Joint Commission on the Accreditation of Hospitals; and,
- Meet the requirements set forth in 42 CFR Part 441, Subpart D (inpatient psychiatric services for individuals age 21 and under in psychiatric facilities or programs).

3b. Other Mental Health Facility Services (Individuals Age 65 or Older) (MSIS Code=02) (See 42 CFR 440.140(a) and Part 441, Subpart C).--These are services provided under the direction of a physician for the care and treatment of recipients in an institution for mental diseases that meets the requirements specified in 42 CFR 440.140(a).

4. Nursing Facilities (NF) Services(MSIS Code=07) (See 42 CFR 440.40 and 440.155).--These are services provided in an institution (or a distinct part of an institution) which:

- Is primarily engaged in providing to residents:

  -Skilled nursing care and related services for residents who require medical or nursing care;

  -Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

  -On a regular basis, health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities, and is not primarily for the care and treatment of mental diseases; and;

- Meet the requirements for a nursing facility described in subsections 1919(b), (c), and (d) of the Act regarding:

  -Requirements relating to provision of services;

  -Requirements relating to residents' rights; and

  -Requirements relating to administration and other matters.

NOTE: Intermediate Care Facility (ICF) Services - All Other.--This is combined with nursing facility services.

5. ICF Services for the Mentally Retarded (MSIS Code=05) (See 42 CFR 440.150 and Part 483 of Subpart I).--These are services provided in an institution for mentally retarded persons or persons with related conditions if the:

- Primary purpose of the institution is to provide health or rehabilitative services to such individuals;

- Institution meets the requirements in 42 CFR 442, Subpart C (certification of ICF/MR); and

- The mentally retarded recipients for whom payment is requested are receiving active treatment as defined in 42 CFR 483.440(a).

6. Physicians' Services (MSIS Code=08) (See 42 CFR 440.50).--Whether furnished in a physician's office, a recipient's home, a hospital, a NF, or elsewhere, these are services provided:

- Within the scope of practice of medicine or osteopathy as defined by State law; and

- By, or under, the personal supervision of an individual licensed under State law to practice medicine or osteopathy, or dental medicine or dental surgery if State law allows such services to be provided by either a physician or dentist.

7. Outpatient Hospital Services (MSIS Code=11) (See 42 CFR 440.20).--These are preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished:

- To outpatients;

- Except in the case of nurse-midwife services (see 42 CFR 440.165), under the direction of a physician or dentist; and

- By an institution that:

  -Is licensed or formally approved as a hospital by an officially designated authority for State standard setting; and

  -Except in the case of medical supervision of nurse midwife services (see 42 CFR 440.165), meets the requirements for participation in Medicare as a hospital.

8. Prescribed Drugs (MSIS Code=16) (See 42 CFR 440.120(a)).--These are simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease or for health maintenance that are:

- Prescribed by a physician or other licensed practitioner within the scope of professional practice as defined and limited by Federal and State law;

- Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

- Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

9. Dental Services (MSIS Code=09) (See 42 CFR 440.100 and 42 CFR 440.120 (b)).--These are diagnostic, preventive, or corrective procedures provided by or under the supervision of a dentist in the practice of his or her profession, including treatment of:

- The teeth and associated structures of the oral cavity; and

- Disease, injury, or an impairment that may affect the oral or general health of the recipient.

A dentist is an individual licensed to practice dentistry or dental surgery. Dental services include dental screening and dental clinic services.

NOTE: Include services related to providing and fitting dentures as dental services. Dentures mean artificial structures made by, or under the direction of, a dentist to replace a full or partial set of teeth.

Dental services do not include services provided as part of inpatient hospital, outpatient hospital, non-dental clinic, or laboratory services and billed by the hospital, non-dental clinic, or laboratory or services which meet the requirements of 42 CFR 440.50(b) (i.e., are provided by a dentist but may be provided by either a dentist or physician under State law).

10. Other Licensed Practitioners' Services (MSIS Code=10) (See 42 CFR 440.60).--These are medical or remedial care or services, other than physician services or services of a dentist, provided by licensed practitioners within the scope of practice as defined under State law. The category "Other Licensed Practitioners' Services" is different from the "Other Care" category. Examples of other practitioners (if covered under State law) are:

- Chiropractors;

- Podiatrists;

- Psychologists; and

- Optometrists.

Other Licensed Practitioners' Services include hearing aids and eyeglasses only if they are billed directly by the professional practitioner. If billed by a physician, they are reported as Physicians' Services. Otherwise, report them under Other Care.

Other Licensed Practitioners' Services do not include prosthetic devices billed by physicians, laboratory or X-ray services provided by other practitioners, or services of other

practitioners that are included in inpatient or outpatient hospital bills. These services are counted under the related type of service as appropriate. Devices billed by providers not included under the listed types of service are counted under Other Care.

Report Other Licensed Practitioners' Services that are billed by a hospital as inpatient or outpatient services, as appropriate.

Speech therapists, audiologists, opticians, physical therapists, and occupational therapists are not included within Other Licensed Practitioners' Services.

Chiropractors' services include only services that are provided by a chiropractor (who is licensed by the State) and consist of treatment by means of manual manipulation of the spine that the chiropractor is legally authorized by the State to perform.

11. Clinic Services (MSIS Code=12) (See 42 CFR 440.90). -- Clinic services include preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that are provided:

- To outpatients;

- By a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients including services furnished outside the clinic by clinic personnel to individuals without a fixed home or mailing address. For reporting purposes, consider a group of physicians who share, only for mutual convenience, space, services of support staff, etc., as physicians, rather than a clinic, even though they practice under the name of the clinic; and

- Except in the case of nurse-midwife services (see 42 CFR 440.165), are furnished by, or under, the direction of a physician.

NOTE: Place dental clinic services under dental services. Report any services not included above under other care. A clinic staff may include practitioners with different specialties.

12. Laboratory and X-Ray Services (MSIS Code=15) (See 42 CFR 440.30).--These are professional or technical laboratory and radiological services that are:

- Ordered and provided by or under the direction of a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by State law or ordered and billed by a physician but provided by referral laboratory;

- Provided in an office or similar facility other than a hospital inpatient or outpatient department or clinic; and

- Provided by a laboratory that meets the requirements for participation in Medicare.

- X-ray services provided by dentists are reported under dental services.

13. Sterilizations (MSIS Code=24) (See 42 CFR 441, Subpart F).--These are medical procedures, treatment or operations for the purpose of rendering an individual permanently incapable of reproducing.

14. Home Health Services (MSIS Code=13) (See 42 CFR 440.70).--These are services provided at the patient's place of residence, in compliance with a physician's written plan of care that is reviewed every 62 days. The following items and services are mandatory.

- Nursing services, as defined in the State Nurse Practice Act, that is provided on a part-time or intermittent basis by a home health agency (a public or private agency or organization, or part of any agency or organization, that meets the requirements for participation in Medicare). If there is no agency in the area, a registered nurse who:

  -Is licensed to practice in the State;

  -Receives written orders from the patient's physician;

  -Documents the care and services provided; and

  -Has had orientation to acceptable clinical and administrative record keeping from a health department nurse;

- Home health aide services provided by a home health agency; and

- Medical supplies, equipment, and appliances suitable for use in the home.

The following therapy services are optional: physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or by a facility licensed by the State to provide these medical rehabilitation services. (See 42 CFR 441.15.)

Place of residence is normally interpreted to mean the patient's home and does not apply to hospitals or NFs. Services received in a NF that are different from those normally provided as part of the institution's care may qualify as home health services. For example, a registered nurse may provide short-term care for a recipient in a NF during an acute illness to avoid the recipient's transfer to another NF.

15. Personal Support Services.--Report total unduplicated recipients and payments for services defined in 15a through 15i.

15a. Personal Care Services (MSIS Code=30) (See 42 CFR 440.167).--These are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are:

- Authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State; and

- Provided by an individual who is qualified to provide such services and who is not a member of the individual's family.

15b. Targeted Case Management Services (MSIS Code=31) (See §1915(g)(2) of the Act).--These are services that are furnished to individuals eligible under the plan to gain access to needed medical, social, educational, and other services. The agency may make available case management services to:

- Specific geographic areas within a State, without regard to statewide requirement in 42 CFR 431.50; and

- Specific groups of individuals eligible for Medicaid, without regard to the comparability requirements in 42 CFR 440.240.

The agency must permit individuals to freely choose any qualified Medicaid provider except when obtaining case management services in accordance with 42 CFR 431.51.

15c. Rehabilitative Services (MSIS Code=33) (See 42 CFR 440.130(d)).--These include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under State law for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

15d. Physical Therapy, Occupational Therapy, and Services For Individuals With Speech, Hearing, and Language Disorders (MSIS Code=34) (See 42 CFR 440.110).--These are services prescribed by a physician or other licensed practitioner within the scope of his or her practice under State law and provided to a recipient by, or under the direction of, a qualified physical therapist, occupational therapist, speech pathologist, or audiologist. They include any necessary supplies and equipment.

15e. Hospice Services (MSIS Code=35) (See 42 CFR 418.202).--Whether received in a hospice facility or elsewhere, these are services that are:

- Furnished to a terminally ill individual, as defined in 42 CFR 418.3;

- Furnished by a hospice, as defined in 42 CFR 418.3, that meets the requirements for participation in Medicare specified in 42 CFR 418, Subpart C or by others under an arrangement made by a hospice program that meets those requirements and is a participating Medicaid provider; and

- Furnished under a written plan that is established and periodically reviewed by:

  -The attending physician;

  -The medical director or physician designee of the program, as described in 42 CFR 418.54; and

-The interdisciplinary group described in 42 CFR 418.68.

15f. Nurse Midwife (MSIS Code=36) (See 42 CFR 440.165 and 441.21).--These are services that are concerned with management and the care of mothers and newborns throughout the maternity cycle and are furnished within the scope of practice authorized by State law or regulation.

15g. Nurse Practitioner (MSIS Code=37) (See 42 CFR 440.166 and 441.22).--These are services furnished by a registered professional nurse who meets State's advanced educational and clinical practice requirements, if any, beyond the 2 to 4 years of basic nursing education required of all registered nurses.

15h. Private Duty Nursing (MSIS Code=38) (See 42 CFR 440.80).--When covered in the State plan, these are services of registered nurses or licensed practical nurses provided under direction of a physician to recipients in their own homes, hospitals or nursing facilities (as specified by the State).

15i. Religious Non-Medical Health Care Institutions (MSIS Code=39) (See 42 CFR 440.170(b)(c)).--These are non-medical health care services equivalent to a hospital or extended care level of care provided in facilities that meet the requirements of Section 1861(ss)(1) of the Act.

16. Other Care (See 42 CFR 440.120(b), (c), and (d), and 440.170(a)).--Report total unduplicated recipients and payments for services in sections 16a, 16b, and 16c. Such services do not meet the definition of, and are not classified under, any of the previously described categories.

16a. Transportation (MSIS Code=26) (See 42 CFR 440.170(a)).--Report totals for services provided under this title to include transportation and other related travel services determined necessary by you to secure medical examinations and treatment for a recipient.

NOTE: Transportation, as defined above, is furnished only by a provider to whom a direct vendor payment can appropriately be made. If other arrangements are made to assure transportation under 42 CFR 431.53, FFP is available as an administrative cost.

16b. Abortions (MSIS Code=25) (See 42 CFR 441, Subpart E).--In accordance with the terms of the DHHS Appropriations Bill and 42 CFR 441, Subpart E, FFP is available for abortions:

- When a physician has certified in writing to the Medicaid agency that, on the basis of his or her professional judgment, the life of the mother would be endangered if the fetus were carried to term; or

- When the abortion is performed to terminate a pregnancy resulting from an act of rape or incest. FFP is not available for an abortion under any other circumstances.

16c. Other Services (MSIS Code=19).--These services do not meet the definitions of any of the previously described service categories. They may include, but are not limited to:

- Prosthetic devices (see 42 CFR 440.120(c)) which are replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice as defined by State law to:

  -Artificially replace a missing portion of the body;

  -Prevent or correct physical deformity or malfunctions; or

  -Support a weak or deformed portion of the body.

- Eyeglasses (see 42 CFR 440.120 (d)). Eyeglasses mean lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optician. It includes optician fees for services.

- Home and Community-Based Waiver services (See §1915(c) of the Act and 42 CFR 440.180) that cannot be associated with other TYPE-OF-SERVICE codes (e.g., community homes for the disabled and adult day care.)

17. Capitated Care (See 42 CFR Part 434).--This includes enrollees and capitated payments for the plan types defined in 17 a and b below. Report unduplicated enrolled eligibles and payments for 17 a and b.

17a. Health Maintenance Organization (HMO) and Health Insuring Organization (HIO) (MSIS Code=20).--These include plans contracted to provide capitated comprehensive services. An HMO is a public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified or State-plan defined. An HIO is an entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

17b. Prepaid Health Plans (PHP) (MSIS Code=21).--These include plans that are contracted to provide less than comprehensive services. Under a non-risk or risk arrangement, the State may contract with (but not limited to these entities) a physician, physician group, or clinic for a limited range of services under capitation. A PHP is an entity that provides a non-comprehensive set of services on either capitated risk or non-risk basis or the entity provides comprehensive services on a non-risk basis.

NOTE: Include dental, mental health, and other plans covering limited services under PHP.

18. Primary Care Case Management (PCCM) (MSIS Code=22) (See §1915(b)(1) of the Act).--The State contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee. Report these recipients and associated PCCM fees in this section.

NOTE: Where the fee includes services beyond case management, report the enrollees and fees under prepaid health plans (17b).

SERVICE HIERARCHY

Experience has demonstrated there can be instances when more than one service area category could be applicable for a provided service. The following rules apply to these instances:

- The specific service categories of sterilizations and abortions take precedence over provider categories, such as inpatient hospital or outpatient hospital.

- Services of a physician employed by a clinic are reported under clinic services if the clinic is the billing entity. X-rays processed by the clinic in the course of treatment, however, are reported under X-ray services.

- Services of a registered nurse attending a resident in a NF are reported (if they qualified under the coverage rules) under home health services if they were not billed as part of the NF bill.

APPENDIX C

Potential Information for Inclusion in Complete Claims File

Note: States may submit the full claims data in two file formats, one for header records and one for line item level formats, or can provide a single file with the claim header repeated for each line item. Claim adjustments must be included as well and must include sufficient information to tie adjustments back to the original claim and line item being adjusted. Stratum 7 claims may be provided in an abbreviated format, as described below.

CLAIM HEADER INFORMATION

Unique claim identifier (e.g., unique ICN, TCN, or other state-assigned number)
Strata assignment (if sampling unit at the header level; otherwise strata assignments should be associated with each line item)
Claim type
Date for payment (date of adjusted payment if record is an adjustment)
Adjustment indicator (field indicating that record is an adjustment)
Claim identifier (ICN, TCN, etc.) of claim being adjusted
Beginning date of service
Ending date of service
Number of line items

Submitted charge
Allowed charge
Disallowed charge
TPL amount paid
Beneficiary copay amount
Paid amount ($0 for denied claims)
Denial code

Payment code, if applicable:

- DRG code
- RUG code
- APC code

Treatment occurrence code (This field indicates whether the service provided exceeded a maximum number of occurrences. If there are multiple occurrences of this field, provide the value in the first field.)
Place of service
Type of service
Diagnosis code (e.g., ICD-9, state-defined) – *provide the first 9 diagnosis codes in the record*

Spenddown indicator
Medicare crossover indicator

Prior authorization #

Beneficiary Information
Beneficiary Medicaid ID
Beneficiary name
Beneficiary date of birth
Beneficiary gender
County, city, state, zip
Recipient aid code (i.e., Medicaid eligibility category)
Waiver/program enrollment
Medicare coverage indicator

Billing Provider Information
Billing provider Medicaid #
Provider specialty (first occurrence only)
Provider type (first occurrence only if multiple provider types are captured)
Billing provider name
Billing provider street address #1
Billing provider street address #2
City
State
Zip code
Phone #
Fax #

Performing Provider Information
Provider of service (performing provider) Medicaid #
Provider specialty (first occurrence only)
Provider type (first occurrence only if multiple provider types are captured)
Provider of service name
Provider of service street address #1
Provider of service street address #2
City
State
Zip code
Phone #
Fax #

Referring provider ID# (if applicable and available in MMIS)
Referring provider name

LINE ITEM LEVEL INFORMATION (all line items must be provided with full claims data)
Line item number
Beginning date of service
Ending date of service
Place of service (if at the line item level)
Type of service (if at the line item level)
Diagnosis code (if at the line item level)

Submitted charge
Allowed charge
Noncovered amount
TPL payment
Beneficiary copay
Paid amount ($0 for denied claims)

Number/units of service
Procedure code (e.g., HCPCS, CPT, ICD-9 procedure code, state-specific procedure code)
Procedure code modifier #1
Procedure code modifier #2
Procedure code modifier #3
Procedure code modifier #4
Revenue code
Revenue code description
NDC code (pharmacy claims)
Date prescribed (pharmacy claims)

Stratum 7 includes Medicare premium payments for Medicaid beneficiaries and potentially other payments not necessarily captured in the MMIS in claim format. In the case of Medicare premium payments, states should submit "claim" records including the Beneficiary Information (ID number, name, demographics, aid category, payment amount), a code indicating the nature of the benefit or service for which payment is rendered (e.g., HIPP, Medicare Part B, etc.), the date of payment, and the "service" date or time period for which payment is being made. Each state participating in the program may have issues or constraints regarding what information is available and how it is to be compiled. Lewin will work with each state individually to answer any questions and identify a workable method for providing the necessary data.

APPENDIX D

Data Transmission Cover Sheet

Complete and submit this cover sheet (electronically or in hard copy) with every PERM data submission.

1. Contact person for data questions

Name: Phone: Email:

Title and Organization:

2. File information

Quarter:

Data contents: Universe _____

Details for selected sample _____

Replacement data (describe) _____

Data filenames:

File format (e.g., text, Excel, SAS):

File media (e.g., CD, DVD, tape):

Password(s):

Documentation filenames (if submitted):

Two copies of data ____ (not applicable to data sent on tape media)

3. Options

Complete claims ____ OR Claims extract ___

Claims reflect adjustments ____ OR
State is opting to submit adjusted data later ____

4. Control totals

(Note: Control totals are not required for details on samples, only universe and replacement universe data. If a replacement subset of the universe is being submitted, complete only the applicable cells.)

State: Quarter:

	Month	Month	Month
Stratum 1 Total Lines			
Stratum 1 Total $$			
Stratum 2 Total Lines			
Stratum 2 Total $$			
Stratum 3 Total Lines			
Stratum 3 Total $$			
Stratum 4 Total Lines			
Stratum 4 Total $$			
Stratum 5 Total Lines			
Stratum 5 Total $$			
Stratum 6 Total Lines			
Stratum 6 Total $$			
Stratum 7 Total Lines			
Stratum 7 Total $$			
Stratum 8 Total Lines			
Stratum 8 Total $$			

5. Identification of potential data discrepancies

Please indicate whether there have been any major programmatic changes since the last quarter (e.g., introduction of a large managed care program, significant benefit changes or limitations introduced this quarter) that substantially impact the total dollars in the universe or distribution of dollars among strata, compared to previous quarters. If possible, provide an estimate of the impact of the changes (e.g., 10% decrease in overall FFS spending in Q3).

_____

_____

_____

_____